BOARD OF COMMUNITY HEALTH
August 10, 2006

The Board of Community Health held its regularly scheduled meeting in the Floyd Room, 20th Floor, West Tower, Twin Towers Building, 200 Piedmont Avenue, Atlanta, Georgia. Board members attending were Jeff Anderson, Chairman; Richard Holmes, Vice Chairman; Mark Oshnock, Secretary; Mary Covington; Inman C. "Buddy" English, M.D.; Kim Gay; Robert A. Lipson, M.D.; Ross Mason; and Ann McKee Parker, Ph.D. Commissioner Rhonda Medows was also present. (A List of Attendees and Agenda are attached hereto and made official parts of these Minutes as Attachments # 1 and # 2).

Mr. Anderson called the meeting to order at 12.06 p.m. The Minutes of the July 13, 2006 meeting were UNANIMOUSLY APPROVED AND ADOPTED.

Mr. Anderson began his opening comments and reviewed the agenda. He announced that this would be his last meeting as chairman and would resign effectively August 11, 2006.

Mr. Anderson called on Dr. Medows for the Commissioner's Report. Dr. Medows read a letter to Mr. Anderson from Governor Sonny Perdue, thanking Mr. Anderson for his dedication, friendship, professionalism and leadership to the Department of Community Health. Mr. Anderson acknowledged and thanked the audience and DCH senior staff for their passion for the patients, a passion to do right and a passion to be good stewards of the public trust. He then called on Carie Summers, Chief Financial Officer, to give an update on the Upper Payment Limit and Disproportionate Share Hospital Programs.

Ms. Summers said the Department received final approval from the Centers for Medicare and Medicaid Services (CMS) on both the UPL and DSH programs. DCH has proceeded with making about $250 million in UPL payments to about 100 hospitals across the state. Ms. Summers stated that tonight the Department will be cutting checks for DSH payments for the second half of the allocation for FY 2006. The DSH payments will go to approximately 99 hospitals across the state and the total payout will be $209 million. The total DSH payments for the year, including the interim payment, will total $417 million. The bottom line for the hospital supplemental payment program in FY 2006 is $669 million in total payments; hospitals will net about $429 million from those supplemental payments.

Ms. Summers continued with a presentation on the Amended FY 2007 and FY 2008 Program Budgets. She began by giving an overview of the people served, the budget, cost management efforts and preliminary fiscal status of Medicaid, PeachCare for Kids and State Health Benefit Plan programs.

Ms. Summers stated that Georgia Medicaid serves 1.3 million Georgians and the total budget is $7.7 billion, including $2.3 billion state funds. Members are served through the Medicaid Managed Care and Fee For Service delivery models. She reviewed Medicaid Cost Management Initiatives to date. In FY 2004-2005 these initiatives included changes to the Pharmacy program and changes to outpatient hospital reimbursement. In FY 2006, the Department implemented Care Management Organizations (CMO) programs for low income Medicaid and PeachCare for Kids, disease management for select aged, blind and disabled members, changes to eligibility criteria, and Medicare Part D implementation. For FY 2007, the Department is slated to begin Administrative Services functions for non-CMO members, which includes clinical reviews, fraud and abuse and enforcement of various levels of care determinations. Ms. Summers said these initiatives have all been things that the Department has done in order to bring down the annual increases in Medicaid expenditures. In 2003, the Medicaid budget experienced double-digit growth of almost 15% in terms of the dollars that the Department asked for in Medicaid benefit expenditures. Through 2006, the Department has been able to drop those percentage changes down to under 5%. She said she did not expect this trend to go any lower.

Ms. Summers continued with an overview of the FY 2006 expenditures. Incurred expenses are projected to be about 4.5% higher than FY 2005, primarily because Medicaid enrollment increased 1.67%, growth in waiver programs, increase in physician and inpatient hospital services which were offset by decreases in net drug expenses from Medicare Part D and interim payments made to hospitals for outpatient services. The Department estimates it will carry over about $283 million; of that, $166 million was planned. As part of the FY 2007 Appropriations Act, House Bill 1027 did assume that about $166 million would be rolled forward in surplus from FY 2006 into FY 2007 to support the DCH budget. The remaining $117 million is accounts receivables that are due from the Department of Human Resources ($100 million) and recovery of prospective payments ($17 million).

Ms. Summers moved on to the current status of FY 2007. She said the incurred expenses are projected to be 4.3% higher as compared to FY 2006 due in part to a 1.22% growth in enrollment. Ms. Summers said that since FY 2006 has not been closed, the Department thinks its current appropriations are likely enough to cover projected cash expenditures in FY 2007; therefore the Department probably will not ask for a supplemental budget for Medicaid. Areas that could change the FY 07 status are: changes in the FY 06 final carry forward amount, enrollment changes, and implementation of services functions for the ABD population.

Ms. Summers said in FY 2008, the department would expect benefit expenditures to be 5.8% higher as compared to FY 2007. She stated that the growth in state fund need is disproportionately more than the growth in total fund need because there will be no carry forward funding left to bring into FY 2008, projected 3.75% enrollment growth, and assumed inflationary growth in CMO capitation rates. The Department estimates that $250-$300 million in Medicaid benefit state funds will be needed for FY 2008 to cover the $166 million hole in the budget, enrollment growth and inflationary growth in CMO capitation rates. After addressing questions from the Board, Ms. Summers moved on to the PeachCare for Kids fiscal status.

Ms. Summers said the snapshot of PeachCare is this program serves about 250,000 children and the FY 07 budget is about $250 million in total. Items impacting the fiscal status are enrollment (since FY 2005 there has been a 19% increase in average monthly enrollment), conversion to capitation (Per Member Per Month projected in the CMO is higher than Fee For Service, and cash to accrual basis change in federal funds), and limited federal funds. The Department receives federal funds through the State Children's Health Insurance Program (SCHIP), and those funds are allocated to states to expand health assistance to uninsured and low-income children. The issue for the Department of Community Health is the way the funding is allocated across states. The SCHIP allotment formula has not changed since its inception in 1997, does not consider maintenance of effort, is not reviewed annually to consider policy and population changes; and states have a long time to spend surplus. In FY 07 prior year roll-forward will be gone and the program will be solely dependent on the state's annual allotment. While the annual allotment is about $130 million, Georgia's needs are close to $300 million—a $140.6 million federal deficit in FY 07 and a projected $178.7 million deficit in FY 08. She said the Governor's Office and Dr. Medows are working with members of Congress and CMS to try getting the funding formula changed.

Dr. Medows stated that the most important thing is to get the national surplus redistributed now. Dr. Medows, Abel Ortiz, the Governor's policy advisor, and the Governor's Washington office, have paid visits to six congressional offices, talking to the point about there is not a deficit in SCHIP, but there is a deficit for 18 states including Georgia. Dr. Medows stated that Georgia's concern is that it does not need to actually lobby congress for new appropriations because the money is there; it can be reallocated and shorten the time frame for reviewing and redistributing funds instead of letting surpluses sit year to year. Dr. Medows said other options that have been discussed are direct state appropriations to cover the loss and considering if that population could be addressed through Medicaid. Dr. Medows said the present allotment formula actually penalizes the State. The formula is based on a percentage of uninsured children in the State. Children on SCHIP are considered insured children, so the more children moved into SCHIP, the smaller the pool, and therefore the state's allotment is less. Dr. Medows said a proposal for an alternative formula would take into account the maintenance of effort for children already in SCHIP and address new, uninsured children.

Ms. Summers moved onto the State Health Benefit Plan (SHBP). The SHBP provides healthcare coverage to 641,422 state employees, school system employees, retirees and their dependents. DCH is expecting a 2.5% enrollment rate in FY 2007 and an expenditure growth rate of 12%. Some of the recent changes to SHBP in trying to keep annual growth down are: in FY 2005 the plan changed the pharmacy plan design, started a consumer driven health care pilot program, validated dependent eligibility through audits, and received revenue increases from the state and employee premiums. In FY 2006, the SHBP instituted HMO cost sharing, increased cost sharing for non-preferred drugs in the PPO option, instituted surcharges for smoking and spouses with access to other insurance, revenue increases from both state and employee premiums, and expanded consumer driven health plan pilots. The SHBP converted to a calendar year beginning January 1, 2006. United Health Care took over administering the PPO as well as the third party administrator functions, Medicare Part D was implemented and some administrative contracts were consolidated. For Calendar Year 2007, there will be no employee premium increases. The impact of these changes will save the Plan about $900 million by the end of FY 2009. Some of the cost drivers that keep the trend about 11-13% are membership growth, medical inflation and utilization. She said DCH has no control over

enrollment and minimal impact on medical inflation; the opportunity for impact on cost control is utilization. Revenue need for FY 2008 is $215 million total funds.

Ms. Summers said the Governor's budget instructions for DCH are to request an amount equivalent to continuation growth to cover status quo growth in program enrollment and cost. The Department may discuss enhancement options with the Governor during the fall. The next step is to ask the Board at the August 24 board meeting to approve a budget that would be submitted to the Governor's Office of Planning and Budget on September 1. Ms. Summers concluded her presentation. (A copy of the Amended FY 2007 & FY 2008 Program Budgets presentation is attached hereto and made an official part of these Minutes as Attachment # 3).

Mr. Anderson called for a short break. After the break he called on Charemon Grant, General Counsel, to discuss the final adoption of Certificate of Need Rules Chapter 111-2-2-.06 & .10. She stated that the proposed changes are housekeeping changes. Changes are reflected in Section .02 modifying the number of copies that applicant is required to submit and Section .10 modifies the location to which the applications must be submitted. Ms. Grant stated that the Department received no public comments. Mr. Oshnock MADE a MOTION to approve for final adoption Certificate of Need Rules Chapter 111-2-2-.06 and .10. Mr. Mason SECONDED the MOTION. Mr. Anderson called for votes; votes were taken. The MOTION was UNANIMOUSLY APPROVED. (Copies of Certificate of Need Rules 111-2-2-.06 and .10 are attached hereto and made official parts of the minutes as Attachment # 4).

Mr. Anderson recognized State Representative Michele Henson and Mr. Jim Lientz, the Governor's Chief Operating Officer.

Mr. Anderson asked Mark Trail, Chief, Medical Assistance Plans, to update the Board on the Department's change in policy relative to therapy visits in the Children's Intervention Services (CIS) program. Mr. Trail pointed out one difference in the policy that the Department has made as a result of continuing discussions with a variety of stakeholder groups. The Department is dropping the requirement related to requiring the therapists to coordinate care across therapy specialties. As a result of those conversations, DCH's approach is to encourage coordination of care, utilizing the ASO vendor when that vendor comes on board. Mr. Trail said staff met with the CMO Medical Directors and anticipates another meeting possibly next week to include the Department's review organization. The purpose is to talk about opportunities to have more consistent policies, understanding that each of the CMOs has their own financial risks and will ultimately own their policy.

Dr. Medows asked Mr. Lientz to share a few comments. Mr. Lientz thanked Mr. Anderson personally for the effort, energy and professionalism he put into his role as Chairman of the Board. He said he also looked forward to working with the new officers of the Board.

Mr. Anderson asked Kathy Driggers, Chief, Managed Care and Quality, to give a status report of the Georgia Healthy Families (GHF) Program. Ms. Driggers began with a review of the Atlanta and Central Regions implementation. As of the end of July, there are 591,574 members enrolled in GHF; the three CMOs have paid a total of $47 million as of August 8 for hospital, physician and ancillary claims (this excludes behavioral health, dental and vision subcontractors). The CMOs have also paid $21 million in pharmacy claims. Some of things done to get ready for the June 1 implementation (as well as the September 1 implementation) include using a War Room strategy—on-site CMO expeditors, daily standup meetings to review performance and issues, daily reporting metrics and flash reports, and daily teleconferences with professional provider associations.

Ms. Driggers listed lessons learned during the June 1 implementation—things that GHF is trying to do better for September 1: 1. Transition of care – each CMO plans had a 30-day grace period when they were being very lenient with their own approval policies and prior authorization requirements. The lesson learned is the grace period may need to be lengthened going forward for September 1. The Department found that more intensive education was needed with providers on CMO policies and procedures; 2. Provider Contracting and Loading – there were significant provider contracting and loading issues. This also contributed to some slow claims payment and late contract volume created backlogs and payment delays to providers. All plans have mitigation strategies in effect to minimize the backlog for September 1. 3. Claims Coding and Submission – unique billing and coding practices under the FFS program created some significant payment issues for the CMOs. The CMOs are not required to replicate those practices but some have changed their rules to more closely reflect Medicaid's. Also differences in web capabilities between the GHP and CMO web portals impacted the providers' ability to identify and check claims status. There are also EDI transmission issues that may delay claims payments.

Ms. Driggers continued with plans for the September 1 implementation for the North East, Southeast, and Southwest Regions. As of August 8, some members are scheduled for an August 13th auto-assignment. Normally that process runs on the 24th of every month. This early run is to give the plans ample time to reach out to their new members to make sure they have ID cards as of September 1. The membership that is due for auto-assignment on August 13 includes 227,000 members; of those eligible, about 76,000 members have made a plan selection—a 33% selection rate. Of the 218,000 eligible members scheduled for auto-assignment on September 24, 42,138 members have made a selection (19% selection rate) and will be effective October 1.

Ms. Driggers said other activities for September 1 are IT Readiness. The Department's Readiness Review Vendor, FourThought Group, reviewed all vendors, including ACS, ESI, Maximus individually and as a whole. The results of those readiness reviews indicate a "GO" decision for September 1, 2006 for all sessions. No major issues were found for IT functions. Provider Networks are reviewed on a separate basis.

Ms. Driggers said in summary lessons learned from June 1, 2006 are networks will continue to grow and improve after implementation; parts of our state have limited or inadequate access to providers in general, particularly for certain specialty types; each of the plans is continuing to aggressively develop their networks throughout the North, East, Southeast and Southwest regions; and unless an individual plan in an individual region can demonstrate a comprehensive plan to provide adequate access, that CMO will not be able to go forward, and the Department will have to default to alternative delivery systems. Ms. Driggers concluded her report after addressing questions from the Board. (A copy of the GHF Program Status is attached hereto and made an official part of these Minutes as Attachment # 5).

Mr. Anderson changed the order of the agenda and moved to new business. He polled the Board for the Selection of Officers. The nominations were as follows: Richard Holmes, Chairman; Ross Mason, Vice Chairman; and Mark Oshnock, Secretary. Mr. Anderson called for votes; votes were taken. The following officers were elected: Richard Holmes, Chairman; Ross Mason, Vice Chairman; and Mark Oshnock, Secretary.

Mr. Anderson resumed the agenda and called for updates from each of the CMOs. Mr. Craig Bass, Chief Executive Officer, Amerigroup Community Care in Georgia, described hurdles the Amerigroup has to overcome and lessons learned. The biggest hurdle has been timely adjudication of getting information into systems that allow claims processing to occur. That includes delays in hospital contracting (many were executed by hospitals after go-live), general volume due to late contracting, full credentialing required 30 days before provider could be active, and volume of contracts received around June 1 were difficult to process quickly. Another challenge has been prior authorization (PA) requests. Amerigroup reallocated FTE resources to speed processing and response to providers for PA requests. Mr. Bass described Amerigroup's mitigation strategies: encourage providers to contract in a timely way, request DCH permission to do "interim credentialing," extend continuity of care and "practice period for provider PA requirements from 30 days to 60 days, pay non-participating providers (excluding hospitals) at 100% for at least the first 60 days after go-live to allow more time for the provider to contract with Amerigroup, and add five additional staff to load and configure provider contracts.

Next, the board heard from David McNichols, Chairman and CEO of Peach State Health Plan. Mr. McNichols said PCHP went live on June 1 with approximately 213, 000 lives in the Atlanta and Central regions, and today the enrollment is about 234,000. He said the medical management operations process has been very stable since its inception. An important issue to PCHP is adequate coverage in rural areas using the geo access standards. PSHP will continue to do proactive community outreach to members, providers and industry leaders; collaborative resolution of provider-specific issues including increasing staff to process claims, claims submission assistance, patient allocation assistance and additional training and education; and daily scheduled calls with DCH to report progress and provide additional insights and ideas for solutions. He said PCHP has been focused the last 45 days on addressing issues, getting claims paid and working diligently to make sure the backlog is solved within the next week. Because of the issues with electronic claims submissions and claims payments, PCHP has daily calls with DCH to report its status, improvements, and action plan. Mr. McNichols said PCHP's 60-day observations are provider input to all claims filing systems has been instrumental in improving claims policies; ongoing training opportunities to providers and staff are important; and open communication between doctors, patients and insurers is critical for issue resolution.

Finally, Mike Cotton, Chief Operating Officer, WellCare Health Plan of Georgia, gave a review of WellCare's lessons learned, its focus, and what it will be doing going forward. They are receiving applications and contracts on a daily basis and are confident that they will be able

to achieve and exceed network access requirements. WellCare is adding regional offices in each major metropolitan area and some rural areas to get ready for go-live, making sure that members are receiving ID cards and member materials. In addition, WellCare is conducting ongoing educational meetings with providers to assure understanding of the application process, program policies, EDI submission, and EFT payments. Mr. Cotton said some of the critical activities WellCare is focusing on include: finalizing provider agreements, completing a systematic loading process of provider data, working on a clear communication of program requirements to providers, office staff, and WellCare field representatives, and meeting with key stakeholders throughout the four regions. Mr. Cotton highlighted some of WellCare's achievements: identified 97 high-risk and teen OB cases and coordinated outreach programs to make sure these members are receiving prenatal care; provided $20,000 in over-the-counter drugs and medication to Medicaid members at no cost; and identified 270 high utilizers of emergency services, addressing those issues, outreaching to the member and connecting them with primary care physicians. In addition, WellCare is working to make sure authorizations are placed in the system and processed correctly within the timeframe stipulated by the Department. WellCare has a SWAT team approach to identify developing issues with providers. Mr. Cotton stated that claims payments are a critical issue. WellCare runs checks three times per week and have processed almost 300,000 claims, making about $43 million in payments for all services. Ninety percent of providers are on EDI and there are some glitches, but WellCare is continuing to work on getting providers on EDI and EFT. Mr. Cotton said some lessons learned are: selectively extend transition of care timeframe; selectively adjusting some of its medical management policies and contract requirements; assure consistent messaging and instructions to providers; increasing staff on claims, customer service, and authorization processing; placing field staff in provider offices and working closely with provider partners.

Mr. Holmes called for public comment. Dan Eysie, Diane Jarvis, Karen Bennett accompanied by Jennifer McCullough and Janet Hendrix, and Dr. Eric Brown provided public comment.

There being no further business to be brought before the Board at the meeting Mr. Holmes adjourned the meeting at 3:19 p.m.

THESE MINUTES ARE HEREBY APPROVED AND ADOPTED THIS THE _____ DAY OF _____, 2006.

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RICHARD L. HOLMES
Chairman

ATTEST TO:

_____
MARK D. OSHNOCK
Secretary

Official Attachments:

#1 List of attendees
#2 Agenda
#3 Amended FY 2007 & FY 2008 Program Budgets
#4 Certificate of Need Rules 111-2-2-.06 and .10
#5 GHF Program Status